American Hospital Association

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May 24, 2007

Via ECFS
Marlene H. Dortch
Secretary
Federal Communications Commission
445 Twelfth Street, SW
Washington, DC 20554

Re: Reforms to Rural Health Care Universal Service Program WC Docket No. 02-60

Dear Ms. Dortch:

The American Hospital Association (AHA), on behalf of our nearly 5,000 member hospitals, health care systems and other health care organizations, and our 37,000 individual members, applauds the Federal Communications Commission's (the Commission) recent efforts to make support more accessible to rural health care providers. Despite the urgent need for universal service support for rural health care providers, as recognized by Congress,[i] use of the Commission's current Rural Health Care Universal Service Program has been strikingly limited.[ii] As the Commission noted, there are a number of factors that may explain the underutilization of this important fund.[iii] These include a lack of awareness of the program among rural health care providers, the complexity of the application process, and the relatively small discount levels available. The AHA is optimistic that the Commission's Pilot Program will encourage the deployment of broadband infrastructure to reach rural health care facilities,[iv] and encourages the Commission to monitor the Pilot Program's progress and, if it is successful, make it permanent.

More can be done, however, to help the Rural Health Care support mechanism more effectively deliver vital medical services to rural America. Many of our members – such as Sanford Health in Sioux Falls, SD, St. Claire Regional Medical Center in Morehead, KY, and Intermountain Health Care in Utah and Idaho – provide health care services in very rural settings and are precisely the type of entities that universal service support is intended to benefit. On behalf of our members, the AHA presents the following proposals for further reform of the Rural Health Care Universal Service Program.[v]

PROVIDE SUPPORT FOR INTERNAL CONNECTIONS WITHIN RURAL HEALTH CARE FACILITIES

Internal connections are crucial in rural health care facilities, and providers increasingly rely on technology that requires connectivity at the point of patient care. The days of the paper medical chart on a clipboard at the foot of the patient's bed are rapidly giving way to electronic devices that allow the exchange of electronic health records (EHRs) quickly, securely and seamlessly among nurses, doctors and lab technicians who may not be at the same location.

President Bush and Congress have recognized the enormous benefits and efficiencies that are possible with EHRs, and have made it a priority to ensure that all Americans have electronic health records. The president established a goal of ubiquitous EHR adoption by 2014, only seven years from now.[vi] Congress also has shown intense interest in making EHRs a reality,[vii] with Senators Hillary Clinton and Edward Kennedy taking a leading role on the issue. In July 2006, H.R. 4157, a bipartisan bill to advance EHRs, was adopted by the House of Representatives. Without internal connections within rural health care facilities, however, rural patients will lag behind those in urban areas in obtaining the benefits that EHRs offer.

Other technological changes also make internal connections critical. Today's diagnostic technology increasingly incorporates a need for connectivity. For example, medical imaging devices such as MRI machines can transmit digital images directly to radiologists over a broadband connection. Further, the introduction of radio-frequency identification (RFID) technology is bringing enormous benefits and efficiencies, but also requires interconnected devices throughout the health care facility to read RFID tags.

As a result of these and other advances in medical technology, connectivity within health care facilities is critically important – indeed, it is particularly important in rural areas. The need for internal connections support is a natural extension of the value of telemedicine applications in the rural setting. For example, a nurse's ability to update a clinic patient's medical records electronically is even more important when the patient's doctor's office is located in the next town – or even the next major metropolitan area. Similarly, it is more helpful if a rural hospital or adjoining clinic can transmit images directly from its mammography machine to a radiologist's office when the nearest radiologist is 50 miles away.

To serve these needs, the Commission should provide support for rural health care providers' internal connections, similar to the support that is provided to schools and libraries under the E-Rate program.[viii] Since its inception, the E-Rate program has provided support for internal connections within qualifying schools and libraries. As a result, by 2003 100 percent of public schools and over 93 percent of public school classrooms were connected to the Internet.[ix] Similar success should be a goal of the Rural Health Care Universal Service Program.

The existing cap on the overall Rural Health Care support mechanism will ensure that support costs do not become a burden on the fund. If applications exceed available funding, the Commission could adopt rules of priority. Such rules could be based, for example, on the extent to which a provider is located in a rural area[x] and/or the median household income in the county where the provider is located.[xi]

INCREASE THE DISCOUNT PERCENTAGE FOR INTERNET ACCESS

AHA members strongly support a higher discount percentage for Internet access services. Many rural health care providers either lack broadband access to the Internet or must pay exorbitant rates for it. In some cases, these rates are cost-prohibitive, even after accounting for the discount percentage. A higher percentage would bring the price, after the discount, better within their reach. The Commission previously concluded that a 50 percent discount is appropriate in jurisdictions that are "entirely rural" (generally, insular areas).[xii] The AHA believes that at least this discount percentage would be appropriate in *all* rural areas, and should apply more generally. Alternatively, the Commission could provide for a sliding scale of discounts based on some measure of economic need in the area served by the applicant provider, such as average income in the counties served by the facility. A sliding scale based on income would be consistent with discounts provided for services in the E-Rate program,[xiii] and the Commission's decision in its Rural Health Care Pilot Program to provide support for up to 85 percent of the costs for qualifying infrastructure and service costs.[xiv]

Given that total utilization has hovered only around 10 percent of the cap, we do not believe that an increase in the discount percentage will burden the fund. In addition, even at a higher discount level, rural health care providers will still be required to shoulder a significant portion of the cost themselves, protecting against unwise purchasing decisions.

We also believe that increasing the discount percentage will advance national policy goals by creating incentives for broadband deployment in rural areas. Making broadband Internet access more affordable for rural health care providers will increase demand for these services in rural areas. This increased demand will in turn "pull" deployment into less densely populated areas, which will benefit residents and businesses in addition to rural providers. In this way, increasing the discount percentage will work with the Pilot Program to further the national goal of increased rural broadband deployment.

PROVIDE SUPPORT FOR VOIP SERVICES

Many of the AHA's members have benefited, or would like to benefit, from the lower prices and increased functionality available from new Voice over Internet Protocol (VoIP) service. However, because the Commission has never determined whether VoIP constitutes a "telecommunications service," it does not appear that VoIP services are eligible for support.[xv]

There is no statutory barrier to including VoIP in the list of supported services for rural health care providers. The Commission's statutory mandate extends to providing support for "advanced telecommunications and information services" for providers,[xvi] and the Commission already provides support for Internet access, an information service.[xvii]

VoIP services should be supported based on a percentage discount, just as the Commission currently provides for Internet access, rather than a distance-sensitive discount. VoIP service charges generally are not distance-sensitive, and the Commission's mandate to support providers' access to advanced services is not distance-focused.[xviii] As a result, a percentage discount is the most appropriate type of support for VoIP services.

IMPROVE PROGRAM INFORMATION AND OUTREACH

Many AHA members who could benefit from the Rural Health Care support mechanism have not done so because they find the program's complexity daunting. This impression is corroborated by other members who do participate and find the process burdensome. The Commission should strive to simplify the burdens on both health care providers and carriers.

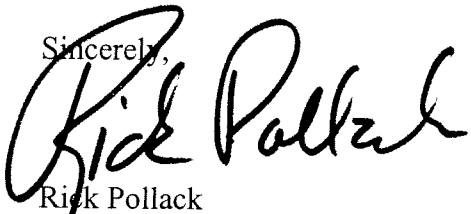
One simple but effective way to improve the application process would be to permit affiliated facilities with multiple rural locations to file consolidated applications, rather than requiring individual applications for each location. The current process creates an enormous burden on applicants – in some cases dissuading entities from applying altogether. There is no reason to believe that allowing consolidated applications would undermine the Commission's oversight capabilities.

In addition, the Commission should make greater efforts to educate providers regarding the program's rules and procedures. Rural health care providers often lack the time and resources to pore over the Commission's rules and the Universal Service Administrative Company's Web site to discern how the process works. The Commission should, for example, schedule information sessions around the country. These could be scheduled to coincide with gatherings of health care providers, such as the AHA's own annual membership meeting. The AHA will assist the Commission with outreach opportunities where possible, but we urge the Commission to formulate a concrete outreach plan that includes regular workshops and educational sessions with health care providers.

The AHA applauds the Commission's steps thus far to improve the effectiveness of its Rural Health Care Universal Service Program. However, more can be done to ensure the program meets congressional goals. We urge the Commission to adopt the proposals discussed above in pending rulemaking.

If you have any questions about our remarks, please feel free to contact me or Kristin Welsh, vice president, executive branch relations, at (202) 626-2322 or kwelsh@aha.org.

Sincerely,



Rick Pollack
Executive Vice President

cc (email):

Hon. Kevin Martin
Hon. Michael Copps
Hon. Jonathan Adelstein
Hon. Deborah Taylor Tate
Hon. Robert McDowell
Thomas Navin
Jeremy Marcus

[i] 47 U.S.C. § 254(b)(6), (h).
[ii] *See, e.g., Rural Health Care Support Mechanism,* WC Docket No. 02-60, Order, 21 FCC Rcd 11111, 11113 ¶ 8 (2006) *("Pilot Program Order")* ("Despite the modifications the Commission has made to the rural health care mechanism, the program continues to ge greatly underutilized and is not fully realizing the benefits intended by the statute and our rules.").
[iii] *Pilot Program Order,* 21 FCC Rcd at 11113 ¶ 8.
[iv] *See generally Pilot Program Order.*
[v] These suggestions are offered in the context of the Commission's open rulemaking docket. *Rural Health Care Support Mechanism,* WC Docket No 02-60, Second Report & Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 19 FCC Rcd 24613 (2004) ("FNPRM").
[vi] *Transforming Health Care: The President's Health Information Technology Plan,* White House Press Release, January 21, 2004.
[vii] *See, e.g., Congress Calls for Paperless Health Records,* Anne Broache, CNET News.com (July 27, 2005).
[viii] *See* 47 C.F.R. § 54.506.
[ix] *Waste, Fraud, and Abuse Concerns With the E-Rate Program*, Bipartisan Staff Report for the Use of the House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations (Oct. 18, 2005) *("House Subcommittee Report")* at 48.
[x] For example, the Rural Utilities Service's Distance Learning and Telemedicine Program considers "rurality" as a factor in the grant-making process. *See* http://www.usda.gov/rus/telecom/dlt/2006-program/06dltgrantsappguide.pdf.
[xi] The FCC's E-Rate program considers income in determining the discount factor by reference to participation in the Federal School Lunch program. 47 C.F.R. § 54.505(c).
[xii] FNPRM at ¶ 44.
[xiii] 47 C.F.R. § 54.505(c).
[xiv] *Pilot Program Order,* 21 FCC Rcd at 11115 ¶ 14.
[xv] Indeed, VoIP services do not appear on the list of supported services on USAC's website. *See* http://www.usac.org/rhc/tools/fequently-asked-questions.aspx#5.
[xvi] 47 U.S.C. § 254(h)(2)(A).
[xvii] 47 C.F.R. § 54.621.
[xviii] *Compare* 47 U.S.C. § 254(h)(1)(A) (telecommunications services) *with* 47 U.S.C. § 254(h)(2)(A) (advanced services).